DHHS Transition Form
From MaineCare Section 65H or 65G to 65 M or N Services

*Today's Date: _____ *For Children Currently Waiting for 65G Only: Date of Original Referral to 65G: _____
*For Children Currently Waiting for 65G Only: If There is a Preference, List Preferred Provider:_____
*For Children Currently in Service: Date 65M/N Services to Begin: _____
Child's Name* *(spelled as it appears on the MaineCare Card)***

*First:	*Middle:	*Last:
*DOB:	*SSN:	*Gender:
*MaineCare #:	Race:	

*Child's Current Residence (Legal Address)

*Street:
*Town: *State: ME *ZIP:
*Phone:

Please choose and complete only one of the following guardian types: A, B, or C.

A. Guardian(s)		
Parents First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Legal Guardian (other than Biological parents)	Mailing Address	Phone # Cell # ☐ No Phone
B. Parental Rights & Responsibilities		
Sole First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Shared First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
Shared First & Last Name	Mailing Address	Phone # Cell # ☐ No Phone
C. State Custody		
DHHS Case Worker First & Last Name	Office Address	Cell # Office # Pager#

***DSM-IV WRITTEN DIAGNOSIS AND NUMBER CODE**

Axis I: _____ Axis II: _____

Axis III:_____ Axis IV:_____

Axis V:_____

Current 65G or 65H Agency:	Office Location/Address:	Phone Number:
65G or 65H Staff Person:	Email Address:	
Targeted Case Mgmt Agency:	Office Location/Address:	Phone Number:
Case Manager Name:	Email Address:	

Symptoms/Behaviors That Interfere With the Child's Ability to Function in 1 or More Areas of Life:

_____

_____

_____

_____

_____

How Long have the Symptoms/Behaviors Occurred?_____

Rationale for Why the Child's Presenting Behavior is expected to respond to this therapeutic intervention:

_____

_____

_____

_____

Rationale for Why this Child's Condition Requires a Coordinated, Intensive, Home-Based Treatment Plan of Services:

_____

_____

_____

_____

Medication	Duration	Dose	Schedule	Taking Meds as per Directions? Y or N	Beneficial YES or NO

Current Living Situation /Placement

Permanent Home	***Non Permanent Home***
☐ Biological Parent(s)	☐ Homeless
☐ Adoptive Parent(s)	☐ Legally Emancipated
☐ Caregiver ie. Foster Parent(s)/Next of Kin	☐ V-9 DHHS status

Describe community/natural supports (i.e. family members, church, boys/girls club) that can assist the family:

Please review the following services and check off those, which are currently provided or have been in the past. Any services, which have not been attempted, please describe rationale for not attempting the services, below.

Service	Current	Past	Provider	Frequency	Duration	Active in this Service? YorN	Beneficial Yes or No
Psychiatry/Med Mgt.							
Outpatient Tx.							
Hospital							
Mobile Crisis							
Family Therapy							
Home Based Services							
Partial Hospital Program/Intensive Outpatient Program							
Crisis Unit							
Residential Tx.							
Other							

Please include testing with the date of the testing and a brief summary of the finding/score.

Psychological Testing (i.e. Intellectual testing, Functional Score, LD testing, Pervasive Developmental testing)	Date of Testing	Finding/Score

Length of Service Requested (Total # of Days)_____ Date of Last Covered Day (LCD) Requested_____

Est. Avg. Hours of Service per Week: Total:_____ Est. Clinician:_____ Est. BHP:_____

Total Hours for Covered Period Requested: _____

In order for Treatment to proceed the following Parental/Guardian Approval must be granted. (Please initial after each statement and sign below in Parent/Guardian section)

As the parent/guardian of this child,

1. I agree with the proposed intensive in home child and family treatment service for my child. _____
2. I agree to actively participate in my child's treatment that includes: family meetings, family therapies, individual therapy, as indicated._____
3. I agree to the release of the information contained within this application, but only to a receiving provider agency as part of the treatment planning process. _____
4. I have reviewed all information contained in this document and attest that it is true to the best of my knowledge. _____

My signature below indicates my approval of all the above-initialed statements.

Title	Signature	Date
Parent / Guardian Youth (if own guardian)		

Provider Title/Agency	Signature	Date